DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HEALTH AND RECOVERY SERVICES ADMINISTRATION
Olympia, Washington

To:	All Providers Managed Care Organizations	**Memorandum No: 06-28** **Issued:** June 1, 2006
From:	Douglas Porter, Assistant Secretary Health and Recovery Services Administration (HRSA)	**For information, contact:** 800.562.3022

Subject: Managed Medicare - Medicare Advantage (Part C) Billing and Payments

Effective on and after July 1, 2006, the Health and Recovery Services Administration (HRSA) will change the way it pays co-payments, coinsurance, and deductibles for clients enrolled with Managed Medicare - Medicare Advantage (Part C).

Co-payments

If there is a co-payment due on a claim, the co-payment will be paid as indicated on the Explanation of Benefits (EOB). Bill the claim with an attached Managed Medicare – Medicare Advantage EOB.

Coinsurance and Deductibles

If there is a balance due on a claim that has a coinsurance or deductible:

- HRSA will compare the department's allowed amount to the Managed Medicare allowed amount and pay the lesser of the two up to the coinsurance amount.
- Payment is based on the lesser of the allowed amounts (Medicare Advantage or HRSA's) minus any prior payments made by Managed Medicare – Medicare Advantage and any other third party insurer.
- There may be times when there is a co-payment amount and a coinsurance/deductible amount listed on the same EOB. In those instances, please bill them on one claim form. Bill the services to HRSA exactly as they appear on the Medicare Advantage EOB.
- Indicate the line item number; the amount of the co-payment, coinsurance, or deductible; and "Managed Medicare" in:

  - ✓ The online comments (NTE segment)for Electronically billed claims;
  - ✓ Field 19 on the HCFA 1500; or
  - ✓ Form locater 84 on the UB-92.

Note: You must follow the Managed Medicare guidelines in order to receive proper payment from Managed Medicare and HRSA. If there is no co-payment or coinsurance listed on the EOB and the plan has paid the claim, HRSA will not make a payment on the claim.

Billing Instructions Replacement Pages

Attached are replacement pages i,-ii and H.9-H.18 for HRSA's current *General Information Billing Instructions.*

How do I conduct business electronically with HRSA?

You may conduct business electronically with HRSA by accessing the WAMedWeb at: http://wamedweb.acs-inc.com

How can I get HRSA's provider issuances?

To obtain DSHS/HRSA provider numbered memoranda and billing instruction, go to the DSHS/HRSA website at http://hrsa.dshs.wa.gov (click ***the Billing Instructions and Numbered Memorandum*** link). These may be downloaded and printed.

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Medicare Part B

Benefits covered under Medicare Part B include:

- ✓ Physician services;
- ✓ Outpatient hospital services;
- ✓ Home health;
- ✓ Durable medical equipment; and
- ✓ Other medical services and supplies not covered under Part A.

Note: When the words *"This information is being sent to either a private insurer or Medicaid fiscal agent,"* appear on the Medicare remittance notice, it means that the claim has been forwarded to HRSA or a private insurer for deductible and/or coinsurance processing.

If a provider receives a payment or denial from Medicare, but it does not appear on the HRSA Remittance and Status Report (RA), the provider bills HRSA directly with the Medicare EOMB attached. Submit a HCFA 1500:

- If Medicare has made payment, and there is a balance due from HRSA Bill only those lines Medicare paid. Do not submit paid lines with denied lines; this could cause a delay in payment.

- If Medicare denies services, but HRSA covers them, bill only those lines Medicare denied. Do not submit denied lines with paid lines; this could cause a delay in payment.

- If Medicare denies a service that requires prior authorization (PA) by HRSA, HRSA waives the PA requirement but still requires some form of HRSA authorization based on medical necessity.

HRSA's Payment Methodology – Medicare Part B

- HRSA compares HRSA's allowed amount to Medicare's allowed amount and selects the lesser of the two. Medicare's payment is deducted from the amount selected.

- For the Qualified Medicare Beneficiary if there is no HRSA allowed amount, HRSA uses Medicare's allowed amount.

- If there is *no* balance due, the claim is denied because Medicare's payment exceeds HRSA's allowable.

- If there *is* a balance due, payment is made towards the Medicare deductible and/or coinsurance up to HRSA's maximum allowable.

- HRSA cannot make direct payments to clients to cover the deductible and/or coinsurance amount of Part B Medicare. HRSA *can* pay these costs to the provider on behalf of the client when:

  - ✓ The provider **accepts** assignment; and
  - ✓ The total combined reimbursement to the provider from Medicare and HRSA does not exceed Medicare or HRSA's allowed amount, whichever is less.

Medicare Part C

- Benefits covered under Medicare Part C include:

  - ✓ Physician services;
  - ✓ Outpatient hospital services;
  - ✓ Home health;
  - ✓ Durable medical equipment; and
  - ✓ Other medical services and supplies not covered under Part A.

- If a client is enrolled in a Managed Medicare - Medicare Advantage (Part C) plan submit the claim to the Managed Medicare - Medicare Advantage plan first. Managed Medicare - Medicare Advantage is the primary payer of claims.

- After receiving payment or denial from the Managed Medicare - Medicare Advantage plan, submit the claim to HRSA. Indicate "Managed Medicare" as follows:

  - ✓ HCFA/CMS 1500 in field 19;
  - ✓ UB-92 in form locator 84; or
  - ✓ Electronic billing in the on-line comments.

- HRSA must receive claims within 6 months of the Managed Medicare – Medicare Advantage payment date and must include the Managed Medicare EOB to avoid delayed or denied payment due to late submission.

- HRSA does not accept altered EOB's.

- If the Managed Medicare - Medicare Advantage plan allows a service that requires PA by HRSA, HRSA waives the PA requirement.

Note: Discrepancies, disputes, protests, or justifications for a higher fee or payment for any claim should be directed to your Managed Medicare - Medicare Advantage plan. If Managed Medicare - Medicare Advantage adjusts the payment and the claim has previously been paid, you may submit an adjustment request to HRSA. Submit a new claim if the original claim was denied.

HRSA's Payment Methodology – Managed Medicare - Medicare Advantage (Part C) Plans

In order to receive payment from HRSA, it is necessary to follow the billing guidelines established from the Managed Medicare – Medicare Advantage plan prior to billing HRSA.

If there is a co-payment due on a claim:

- Bill HRSA the co-payment amount for each service or procedure.
- For non capitated co-payment claims ,which require that the Medicare EOB be attached to the claim, you must indicate "Managed Medicare" as follows:
  - ✓ HCFA/CMS 1500 in field 19; or
  - ✓ UB-92 in form locator 84; or
  - ✓ Electronic billing in the on-line comments.
- For capitated co-payments ,which do not require the biller to submit with an EOB, indicate "Managed Medicare capitated co-payment" and line item number as follows:
  - ✓ HCFA/CMS 1500 in field 19; or
  - ✓ UB-92 in form locator 84; or
  - ✓ Electronic billing in the on-line comments.
- Bill services using the appropriate level of coding.

Note: HRSA pays co-payments as indicated when there is a co-payment due for services rendered.

If there is coinsurance or deductible due on a claim:

If there is a balance due:

- Bill all services, paid or denied, to HRSA on one claim form, and attach an EOB.
- Indicate "Managed Medicare as follows:
  - ✓ HCFA/CMS 1500 in field 19; or
  - ✓ UB-92 in form locator 84; or
  - ✓ Electronic billing in the on-line comments.
- HRSA will compare the allowed amount for HRSA and Managed Medicare – Medicare Advantage and select the lesser of the two.
- Payment is based on the lesser of the allowed amounts minus any prior payment made by Managed Medicare – Medicare Advantage.

If there is no balance due, the claim will be denied.

If there is coinsurance, deductible, and co-payment due on a claim:

- Bill all on the same claim form. Bill the services to HRSA exactly as they appear on the Medicare advantage EOB

- Indicate "Managed Medicare" and line item number for the co-payment as follows:

  - ✓ HCFA/CMS 1500 in field 19; or
  - ✓ UB-92 in form locator 84; or
  - ✓ Electronic billing in the on-line comments.

If the Medicare Advantage plan allows a service that normally requires PA by HRSA, HRSA will waive the PA requirement.

QMB (Qualified Medicare Beneficiaries) Program Limitations

For clients who are Qualified Medicare Beneficiaries with Categorically Needy Program or Medically Needy Program (Clients who have CNP or MNP identifiers on their Medical ID card in addition to QMB):

- If Medicare and HRSA cover the service, HRSA pays only the deductible, co-pay and/or coinsurance up to Medicare or HRSA's allowed amount, whichever is less.
- If only Medicare covers the service and HRSA does not, HRSA pays only the deductible and/or coinsurance up to Medicare's allowed amount.
- If only HRSA covers the service and Medicare does not and the service is covered under the CNP or MNP program, HRSA reimburses for the service.
- If HRSA does not have an allowed amount for Managed Medicare – Medicare advantage (formerly Medicare + choice), HRSA pays up to the full co-payment amount

QMB-Medicare Only

For QMB-Medicare Only clients (Clients who have only QMB identifiers on their Medical ID card):

- If Medicare and HRSA cover the service, HRSA pays only the deductible and/or coinsurance up to Medicare or Medicaid's allowed amount, whichever is less.
- If only Medicare covers the service and HRSA does not, HRSA pays only the deductible and/or coinsurance up to Medicare's allowed amount.
- If Medicare does not cover the service, HRSA does not reimburse the service.
- If HRSA does not have an allowed amount for Managed Medicare-Medicare Advantage (formerly Medicare + Choice) HRSA pays up to the full co-payment amount.

How to Complete the HCFA-1500 Claim Form

Note: HRSA encourages providers to make use of electronic billing options. For information about electronic billing, refer to the *Important Contacts* section

The CMS-1500, HCFA-1500, U2, 12-90, or the Health Insurance Claim Form is a universal claim form. The numbered boxes on the claim form are referred to as fields. A number of the fields on the form do not apply when billing HRSA. Some field titles may not reflect their usage for a particular claim type.

If you do not follow these instructions, your claims may be denied or suspended for further processing, also known as adjudication. Either one of these actions will extend the time period for payment.

Guidelines/Instructions for Paper Claim Submission:

- In order for the claim to be read by the OCR, red ink on the blank claim form must be either Sinclair Valentine J6983 or OCR Red Paper. Paper claims must be submitted using these scannable red inks. These inks cannot be duplicated by a computer printer.
- **Do not use red ink pens, highlighters, "post-it notes," stickers, correction fluid or tape** anywhere on the claim form or backup documentation. The red ink and/or highlighter will not be picked up in the scanning process. Vital data will not be recognized. Do not write or use stamps or stickers that say, "REBILL," "TRACER," or "SECOND SUBMISSION" or similar statements on claim form.
- **Use standard typewritten fonts** that are 10 c.p.i (characters per inch). Do not mix character fonts on the same claim form. Do not use italics or script.
- **Use upper case** (capital letters) for all alpha characters.
- **Use black** printer ribbon, ink-jet, or laser printer cartridges. **Make sure ink is not faded or too light!**
- **Ensure all the claim information is entirely contained within the proper field** on the claim form and on the same horizontal plane. Misaligned data will delay processing and may even be missed.
- **Place only six detail lines on each claim form**. HRSA does not accept "continued" claim forms. If more than six detail lines are needed, use additional claim forms.
- **Total each claim form separately**. Do not indicate the entire total (for all claims) on the last claim form. Do not indicate "continued" on claim forms.

HCFA 1500 Field Descriptions

Field No.	Name	Field Required	Entry
1a.	**Insured's ID No.**	Yes	Enter the Patient Identification Code (PIC) – an alphanumeric code assigned to each HRSA client – exactly as shown on the Medical ID card which consists of the client's: • First and middle initials (a dash [-] *must* be used if the middle initial is not available). • Six-digit birthdate, consisting of *numerals only* (MMDDYY). • First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker. • An alpha or numeric character (tiebreaker). • Apostrophes, hyphens and other special characters in a last name are valid and take the place of a letter. *For example:* ➢ Mary C. Johnson's PIC looks like this: MC010667JOHNSB. ➢ John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B ➢ John O'Henry's PIC looks like this: J-102564O'HENA.
2.	**Patient's Name**	Yes	Enter the last name, first name, and middle initial of the client (the receiver of the services for whom you are billing).
3.	**Patient's Birthdate**	Yes	Enter the birthdate of the client.
4.	**Insured's Name (Last Name, First Name, Middle Initial)**		When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, TRI-CARE, or TRI-CAREVA) enter the name of the insured here. Enter the name of the insured except when the insured and the client are the same – then the word *Same* may be entered.
5.	**Patient's Address**	Yes	Enter the address of the client who received the services you are billing for (the person whose name is in Field **2**.)

Field No.	Name	Field Required	Entry
9.	**Other Insured's Name**		If there is other (secondary) insurance (Field 11d), enter the last name, first name and middle initial of the person who holds the other insurance. If the client has other insurance and this field is not completed, payment of the claim may be denied or delayed.
9a.	**Other Insured's Policy or Group Number**		Enter the other insured's policy or group number *and* insured's SSN.
9b.	**Other Insured's Date of Birth and Gender**		Enter the other insured's date of birth and gender.
9c.	**Employer's Name or School Name**		Enter the other insured's employer's name or school name.
9d.	**Insurance Plan Name or Program Name**		Enter the insurance plan name or program name (e.g., the insured's health maintenance organization, private supplementary insurance). **Please note:** DSHS, Medicaid, Welfare, Provider Services, Healthy Options, First Steps, and Medicare, etc., are **inappropriate** entries for this field.
10.	**Patient's Condition Related To**	Yes	Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in Field **24**. ***Indicate the name of the coverage source in field* 10d** (L&I, name of insurance company, etc.).
11.	**Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**		Primary insurance, when applicable. This information applies to the insured person listed in Field **4**. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and Medicaid is the payer of last resort.
11a.	**Insured's Date of Birth**		Primary insurance. When applicable, enter the insured's birthdate, if different from Field **3**.
11b.	**Employer's Name or School Name**		Primary insurance. When applicable, enter the insured's employer's name or school name.
11c.	**Insurance Plan Name or Program Name**		Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(***Note***: This may or may not be associated with a group plan.)*

Field No.	Name	Field Required	Entry
11d.	**Is there another Health Benefit Plan?**	Yes if secondary insurance.	Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed Fields **9a.-d**. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. If **11d.** is left blank, the claim may be processed and denied in error.
17.	**Name of Referring Physician or Other Source**		When applicable, enter the referring physician or Primary Care Case Manager (PCCM) name.
17a.	**ID Number of Referring Physician**		When applicable, 1) enter the 7-digit HRSA-assigned physician number. Refer to the Provider Number Reference website: https://fortress.wa.gov/dshs/pnrmaa/Login.aspx?ReturnUrl=%2fDefault.aspx; 2) If the referring provider does not have an HRSA-assigned ID number, enter 8900946. Use this standard number **only** for referring providers who do not have an HRSA assigned ID number; or 3) When the PCCM referred the service, enter his/her 7-digit identification number here. If the client is enrolled in a PCCM plan and the PCCM referral number is not in this Field when you bill HRSA, the claim will be denied.
19.	**Reserved for Local Use**		This field is used for comments that require an HRSA claims specialist to review a claim before payment is made. Examples of appropriate comments: • "B" for baby on a parent's PIC • "Twin A" or "twin B" • "Triplet A", "triplet B", or "triplet C" • "ITA client" • "NDC" • "backup attached" Inappropriate comments may result in delayed processing of claims.
21.	**Diagnosis or Nature of Illness or Injury**		Enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4.
22.	**Medicaid Resubmission**		When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the *Remittance and Status Report*.)
23.	**Prior Authorization Number**		When applicable. If the service or hardware you are billing for requires prior authorization, enter the assigned 9-digit number. (See Field **24K** for Expedited Prior Authorization (EPA) numbers).

Field No.	Name	Field Required	Entry
24.	**Enter only one (1) procedure code per detail line (Fields *24A - 24K*).** If you need to bill more than 6 lines per claim, please use an additional HCFA-1500 claim form.		
24a.	**Date(s) of Service**	Yes	Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., June 04, 2005 = 060405).
24b.	**Place of Service**	Yes	Enter the appropriate **two digit** code as follows: **Code Number** — **To Be Used For** 11 — Office 31 — Skilled Nursing Facility 32 — Nursing Facility
24d.	**Procedures, Services or Supplies CPT/HCPCS**	Yes	Enter the appropriate procedure code for the service(s) being billed. Modifier: **When appropriate enter a modifier**. If there is more than one modifier, begin the list of modifiers with "99" (e.g., 99 80 59)
24e.	**Diagnosis Code**	Yes	Enter the ICD-9-CM diagnosis code related to the procedure or service being billed (for each item listed in **24D**). A valid diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM current volume or relate each line item to Field 21 by entering a 1, 2, 3, or 4. The first diagnosis should be the principle diagnosis. Follow additional digit requirements per ICD-9-CM.
24f.	**$ Charges**	Yes	Enter your usual and customary charge for the service performed. If billing for more than one unit, enter the total charge of the units being billed. Do not include dollar signs or decimals in this field. Do not add sales tax. Sales tax is automatically calculated by the system and included with your remittance amount.
24g.	**Days or Units**	Yes	Enter the total number of days or units (up to 999) for each line. These figures must be whole units.
24k.	**Reserved for Local Use**		When applicable. Enter the required 9-digit EPA number only on the detail line to which the EPA number specifically applies.
25.	**Federal Tax ID Number**		Leave this field blank.

Field No.	Name	Field Required	Entry
26.	**Patient's Account Number**		Not required (optional field for internal purposes). Enter an alpha or numeric character only. For example, a medical record number or patient account number. Do not enter spaces or the following characters in this field: ***** (asterisk) **~** (tilde) **:** (colon) This number will be printed on your *Remittance and Status Report (RA)* under the heading *Patient Account Number*.
28.	**Total Charge**	Yes	Enter the sum of all charges indicated in Field 24F. Do not use dollar signs or decimals in this field.
29.	**Amount Paid**		If you receive an insurance payment or client-paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from a source(s) other than insurance, specify the source in Field **10d**. Do not use dollar signs or decimals in this field or put prior Medicare or Medicaid payments here.
30.	**Balance Due**	Yes	Enter total charges minus any amount(s) in Field **29**. Do not use dollar signs or decimals in this field.
33.	**Physician's, Supplier's Billing Name, Address, Zip Code And Phone #**	Yes	Enter the provider's *Name* and *Address* on all claim forms. **PIN #**: This is the seven-digit number assigned by HRSA to identify the performing individual when the individual is part of a group (e.g., the MD/ARNP, etc. who performed the service). **Grp #**: This is the seven-digit number assigned by HRSA to the billing entity (e.g., clinic, lab, hospital emergency room, etc.). When a valid group number is entered in this field, payment will be made to this number. **Note**: **When billing a Grp#, you must include a performing provider number in the PIN# field.**

For questions regarding claims information, call HRSA toll-free:

1-800-562-3022